CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME™

TESTIMONY

Delivered by Deborah R. Hoyt, President and CEO
The Connecticut Association for Healthcare at Home
Before the Human Services Committee
March 4, 2014

SUPPORT: HOUSE BILL 5325, AN ACT ELIMINATING THE HOME-CARE COST CAP
SUPPORT: SENATE BILL 254, AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY
SUPPORT: SENATE BILL 325, AN ACT CONCERNING MEDICAID RECIPIENTS WITH COMPLEX MEDICAL NEEDS
SUPPORT: SENATE BILL 250, AN ACT CONCERNING FAIR HEARINGS

Good morning Senator Slossberg, Representative Abercrombie and honorable members of the Human Services Committee. My name is Deborah Hoyt, and I am the President and CEO of the Connecticut Association for Healthcare at Home. The Association represents 60 Connecticut DPH licensed/Medicare certified home health and hospice agencies that foster cost-effective, person-centered healthcare in the setting people prefer most – their own home. Collectively, our agency providers deliver care to more CT residents each day than those housed in CT hospitals and nursing homes combined. As a major employer with a growing workforce, our on-the-ground army of 17,000 home health care workers is providing high-tech and tele-health interventions for children, adults and seniors.

House Bill 5325 is a narrowly drafted bill that would have a significant and positive impact on the elderly population we serve. By eliminating the statutory cap for community-based services, currently set at sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities, more seniors will be eligible to receive quality, cost-effective home-based care. We urge the committee to support and favorably report House Bill 5325.

Senate Bill 254 is a critically important bill for seniors who receive home-based health care. Among other things, this bill would require the Commissioner of Social Services to establish a system to pay for services under the Connecticut home-care program for the elderly for a period of up to ninety days for applicants who require a skilled level of nursing care and who are determined to be presumptively eligible for Medicaid coverage. The bill further would require that the system include:

- the development of a preliminary screening tool to determine whether an applicant is functionally able to live at home or in a community setting and is likely to be financially eligible for Medicaid
- authorization by the commissioner for access agency representatives to initiate home-care services not later than five days after such functional eligibility determination for applicants deemed likely to be eligible for Medicaid
- a presumptive financial Medicaid eligibility determination for such applicants by the department not later than four days after the functional eligibility determination

By providing an expedited system for screening a senior's ability to live at home, initiating home-care services, and establishing Medicaid eligibility to pay for such services, the bill would help more seniors obtain the necessary level of care in their homes and avoid more costly institutional care. We urge the committee to favorably report SB 254.

Senate Bill 325 recognizes and defines an individual as "complex needs patient" as one with significant physical or functional impairment resulting from a medical condition or disease." The bill requires the Commission of Social Services to establish specific reimbursement and billing for individually configured complex rehabilitation technology products and services used by complex needs patients, and to ensure that Medicaid payments for such products and services provides adequate access by complex needs patients and takes into account the significant resources, infrastructure, and staff needed to meet their needs. If passed, this bill will enhance ensure greater and improved health care for complex needs patients.

Senate Bill 250 makes changes to the current Department of Social Services administrative hearing process by establishing an Office of Administrative Appeals within the agency, which office shall be independent from DSS's legal counsel and which shall conduct all appeals from decisions by the Commissioner. We support the bill, which will provide greater impartiality and fairness in the appeals process.

With respect to HB 5325, SB 254 and SB 325, it is critical to note that the agencies that provide home health care have reached a dire juncture in terms of business survival. The "perfect storm" experienced by home health care agencies includes the combined impact of:

- Flat Medicaid reimbursement to home health providers since 2005 – no cost of living adjustment and, at the same time, this period was a time of increased regulatory burden and audit scrutiny. (See Attachment)
- Current 2005 reimbursement rate doesn't come close to covering the cost that home care agencies expend to provide care in 2014 and beyond under the Medicaid program. In fact, agencies report that it only covers 58 to 61 cents on the dollar of care delivered.
- Mission-driven non-profit home health care agencies accept every patient despite their ability to pay. Each Medicaid client, from a financial perspective, adds to the uncompensated losses for that agency. The additional volume of CT Medicaid clients requiring home care in 2014 and beyond as a result of the Affordable Care Act will only add to this situation.
- Significant industry consolidation is occurring. Four non-profit agencies have closed their doors in the past two years as a result of inadequate reimbursement. Eleven home care agencies have been acquired or had a change in ownership in 2012-2013.
- Home care providers have been able to cope with Medicaid underfunding due to margins earned on caring for Medicare clients. However, the Centers for Medicare and Medicaid Services (CMS) issued a new rule that calls for a cut of 3.5% each year from 2014 to 2017. This additional 14% cut (rebasing) to home health care Medicare rates, on top of recent cuts of 6.5%, will result in an overall Medicare margin for CT home care providers of 0.3% by the year 2017. This slim margin is not adequate to offset the current underfunding by DSS for Medicaid clients.

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Home health care agencies need to have appropriate and sustainable Medicaid rates that cover the cost of care to remain viable and invest in the technology and resources to meet the emerging healthcare delivery models in Connecticut. We ask that the legislature invest in the future of the home health care provider sector in 2014 by establishing a Medicaid rate structure that covers the cost of care provided and adjusts appropriately in future years so that the goals of HB 5325, SB 254 and SB 325 - greater access to home and community-based health care – will be achieved.

Thank you.

110 Barnes Road | P.O. Box 90 | Wallingford, CT 06492 | T 203.265.9931 | F 203.949.0031 | CTHealthCareAtHome.org